dinates the visit of the consultant. One of the things we have learned from this experience is that a consultation clinic cannot succeed without local initiative, regardless of the interest of The Arthritis Foundation or consultants.

With ten years of repeated visits by the same consultants, it has been possible to observe some effect of this program, as reflected by changes in actual practice that rheumatologists believe represent better care. For example, in the treatment of rheumatoid arthritis there has been more prolonged use of aspirin and less reliance on brief trials of corticosteroids, or of other nonsteroidal anti-inflammatory agents. Gold which initially was rarely used because of unfamiliarity is now prescribed regularly. The sedimentation rate has been introduced into the "rheumatoid panel" of laboratory tests. Joint aspiration for diagnosis is a more common procedure, and synovial fluid is tested for crystals and leukocytes rather than protein content.

When initially asked to take part, some rheumatologists were reluctant, feeling that the problems would be too complex to make a firm diagnosis or therapeutic decision in such a setting. This fear has proved unfounded. In ten years there have been no more than five occasions when it was appropriate to recommend that the patient be referred to an arthritis center for more extensive investigation. Consultants have been pleasantly surprised to find that the patients present stimulating and interesting problems, and it has been gratifying to learn that even though deprived of detailed laboratory testing, they can arrive at a decision and make recommendations to patient and physician.

The clinic of May 1978 was typical. It numbered 19 patients, including seven with rheumatoid arthritis and one who feared she had the disease. There were two patients each with osteoarthritis, lupus, the Reiter syndrome and fibrositis, and one patient with back pain, one with colitic arthritis and one with early scleroderma.

In summary, this is a description of a method of postgraduate education by means of a quarterly arthritis consultation clinic that has continued to meet for ten years. As measured by one rheumatologist spending a whole day to talk to ten physicians and six other health personnel, it would not be considered an efficient teaching device. From the standpoint of involvement of the learners, continued interest and demonstrated change in habits of rheumatologic practice, it is a demonstrably effective one.

LOUIS A. HEALEY, MD
Seattle

Anaphylaxis to Kissing Bugs

TO THE EDITOR: Recently, I talked with a very frustrated school teacher from the western Sierra foothills of California who had the misfortune of having progressively more severe hives and, later, anaphylactic reactions to kissing bugs (Triatoma). Kissing bugs are nocturnal bugs that must feed on mammal blood to mature, and are found in the low elevation foothills of the Sierra and the desert region of Southern California. The people affected are apparently allergic to the proteins in the saliva, as there is no venom. However, the end result is, in a few people, as serious as that from Hymenoptera stings.

The reason my patient was so frustrated is that she has more than once almost literally staggered into a hospital emergency room where the physician on call has told her that she is hyperventilating, or simply overly nervous, and that this is the reason for her hives, shortness of breath and mental confusion.

The treatment for this type of allergic reaction is the same as for any accelerated drug or insect reaction: administration of adrenalin, antihistamines and corticosteroids as needed to suppress the symptoms, with use of cardiorespiratory resuscitation techniques if the patient's condition becomes that severe.

With increasing numbers of people moving to the high desert and Sierra foothills, there are very likely to be increasing numbers of people affected by these reactions, which characteristically come on in the middle of the night with the person waking up itching and scratching as hives occur. This progresses to shortness of breath with asthma and even changes in voice as laryngeal edema occurs.

Patients should be provided with insect sting kits consisting of an adrenalin syringe, preloaded and ready to use, and chewable antihistamine tablets. They should be instructed to use the adrenalin and the antihistamine and then go to an emergency room. Use of whole body Triatoma extract has been suggested by a few allergists, but there is no proof that such treatment is effective and the recent experience with whole body insect

extract casts doubt on the possibility that this could be effective.

One death from this type of allergic reaction has been recorded in a newspaper (*Merced Star*, May 31, 1975). With growing numbers of people exposed to this problem, research is urgently needed. Until effective preventive treatment is developed, the least we can do is to make sure that all emergency room physicians are aware of the problem. There is a kissing bug and it does cause severe allergic reactions including anaphylaxis.

ROBERT W. MONTGOMERY, MD
Visalia, California

Legionnaires' Disease

TO THE EDITOR: Legionnaires' disease was discussed by Dr. Barbara Kirby in the Medical Staff Conference in the December 1978 issue. It essentially was a review of material previously published by her and her colleagues.[1]

She stated that Legionnaires' disease has not been seen in Los Angeles apart from the Veterans Administration Wadsworth Hospital Center experience. We as a group of three pulmonary practitioners in private practice have discovered 14 cases in four different hospitals in the San Gabriel Valley of Los Angeles County in the last 11 months which meet the Center for Disease Control (CDC) criteria for either a presumed or a confirmed case.[2,3]

Although Dr. Kirby feels that there is a characteristic symptom complex, this has not been our experience. We are unable to separate the clinical presentation of Legionnaires' disease from other infectious pneumonias. Perhaps the sporadic nature of our cases over a large geographic area which conceivably may involve several serotypes might in part explain this difference.

We do not understand her statement that there is not an easy reliable method for diagnosis. In both the CDC's and our experience, the immunofluorescent antibody test has been an easily performed, reliable test. For the last year it has been commercially available through the Analytical Reference Service in Long Beach, California, with results being reported to the clinician in 48 to 72 hours. Initially we had split our specimens and sent one to this laboratory and one to the CDC. Because both laboratories reported the same titer we have stopped sending specimens to the CDC which requires 6 to 8 weeks turnaround time. The most pressing current problem with this test is to incorporate enough of the serotypes to detect all clinical cases.

Doctor Kirby commented that pulmonary cavitation is not seen on x-ray films of the chest. As is so often the case, the more a disease is recognized, the broader its spectrum of clinical manifestations. We have recently observed two cases of Legionnaires' disease with cavitation.[4]

Our experience would suggest that this is not an uncommon disease, that a reliable rapid test is available for diagnosis, and that in patients with pneumonia, physicians should consider Legionnaires' disease when the cause of the pneumonia is not obvious.

JOHN J. VAN DYKE, MD
KEVIN B. LAKE, MD
PETER M. BROWNE, MD
Pasadena, California

REFERENCES

1. Kirby BD, Snyder KM, Meyer RD, et al: Legionnaires' disease: Clinical features of 24 cases. Ann Intern Med 89:297-309, Sep 1978
2. Legonnaires' disease—England, Wales. Morbidity Mortality Weekly Rep 27:200, 205, 1978
3. Legionnaires' disease—United States. Morbidity Mortality Weekly Rep 27:439-441, 1978
4. Lake KB, Van Dyke JJ, Brown PM: Legionnaires' disease and pulmonary cavitation. Arch Intern Med (In press)

* * *

Dr. Kirby Replies

TO THE EDITOR: Dr. Lake and his associates state that the Medical Staff Conference "essentially was a review of material previously published." The conference was held in August 1978, before any detailed publication of the Wadsworth experience. At the time of the conference, 51 cases of Legionnaires' disease had been reported in Los Angeles County; in 49 of these cases exposure to Wadsworth Hospital was documented.[1]

I cannot comment on whether or not the 14 patients mentioned by Dr. Lake and associates had Legionnaires' disease because no data are presented. I would urge any physician who thinks he has diagnosed even a single case of Legionnaires' disease to report it promptly to the appropriate public health authorities so that epidemiologic studies may be undertaken. One of the striking features of Legionnaires' disease is its frequent association with specific buildings and geographic areas. With effective therapy available, early identification of such sources and notification of local physicians may prevent needless morbidity and even death.

As stated in the Medical Staff Conference, Legionnaires' disease at Wadsworth hospital has presented as a readily recognizable clinical entity.